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## ORIGINAL ARTICLES

### THE LAKESIDE PREVENTORIUM.\*

WILLIAM P. BUFFUM, JR., M. D.

PROVIDENCE, R. I.

The Lakeside Preventorium, financed and managed by the Providence Tuberculosis League, was founded in 1912. It is located at Hoxsie, in the town of Warwick, R. I., eight miles to the southwest of Providence, two miles from Narragansett Bay and twenty miles from the ocean. It is on the edge of a large lake and on elevated ground, dry and sandy, with many oak trees which cast sufficient shade in summer. A large natural sand pile makes a good playground for the children and the lake has a good bathing beach which is in frequent use.

#### *Purpose*

The original purpose of the Preventorium was to provide a place where children with various types of tuberculous infection could live under good hygienic conditions. Lately a large number of the patients have been children in poor general nutrition many of whom have been exposed to tuberculosis, but in whom no definite tuberculous disease could be demonstrated. It is for the prevention of the development of clinical tuberculous disease that these children are admitted and thus the name "PREVENTORIUM." Children with active pulmonary involvement are refused admission in order to protect the others from infection.

A few adult females, convalescent from various illnesses are sometimes sent in from the various hospitals.

At the same location large numbers of women and children are taken during the summer for two weeks vacation but these are housed in a separate building and are not considered as members of the Preventorium family.

#### *Buildings.*

The buildings used for preventorium purposes are three in number. The main building, sometimes called "The Home," is used from October

to June. This is a large, square house of twenty-four rooms, formerly a residence, in the general style and proportions of a house built about the time of the Civil War, and suitable for our purposes only in that the halls are large and light and run clear through the house. The house is bare and clean but no important alterations have been made as yet. There is a large porch on the south side and we expect soon to build a second story porch that will be partly glassed in as a protection against extreme weather.

The second building is the "Bungalow." This is used as the preventorium from June to October. It has wide sleeping porches and all the children sleep out doors on these porches during the time this building is used.

The third building is the "Playhouse." This in reality is but a wooden shed, 18 by 60 feet, with no wall on the south side. This is situated on the slope of a sandy hill, and here the school is held and we have found it warm enough to be used with comfort all winter.

The summer or "Vacation" work is carried on in a separate building containing dormitories and a large dining hall. For this summer work the main building is also used as at that time the preventorium children are in the "Bungalow."

A new cottage has just been built for the resident farmer who is an important member of our staff, because we have in all about 30 acres, from some of which we raise many vegetables. We also have a small poultry farm.

#### *Staff.*

The staff consists of the following: The Director, Miss Murray, is a Registered Nurse of wide experience with tuberculosis problems. Her office is at the offices of the Tuberculosis League. As attending physician I examine all applicants for admission and visit the Preventorium once a week. In residence are a resident, graduate, head nurse, and two assistant nurses, three employees for general house work and the farmer.

#### *Expense.*

I have always considered that one of our chief causes for pride has been the results obtained

\*Read before the Providence Medical Association, February 4, 1924.



when compared with our money outlay. If all the expenses of running the institution are added up, including even insurance on buildings but not including the original cost of land and buildings, the maintenance cost, per week, per child, is \$4.99.

Let me again remind you that the children taken down to Lakeside for summer vacations are not patients of the Preventorium and are not considered in this paper.

#### *Types of Children Admitted.*

The children at the Preventorium average about 25 in number. They are admitted for various reasons. Our main duty has been to admit malnourished children who have been considered to be infected with tuberculosis, and then to improve their nutrition and vigor and thus give them the best chance of fighting this infection. We have not had referred to us the right kind of patients in any great number, considering the size of our community. The tendency among physicians, nurses and social workers has been to proceed somewhat as follows: Mr. A is found to have active pulmonary tuberculosis and is sent to the State Sanatorium; the A children are then taken to a clinic and examined and if nothing abnormal is found in the chest by physical examination are taken home again. A conscientious worker may bring them for re-examination in another six months and in the meantime may supervise the diet to a certain extent and see that the weight is followed up in a nutrition class. This kind of follow-up work among the children of tuberculous parents is very valuable, and especially so is that part which gives them the advantages of the nutrition class with the weekly weighing and the formation of good health habits. A preventorium, however, offers methods and conditions of treatment which otherwise are not available, usually, among people of small incomes, and it surely would be a good thing if every malnourished child with a known exposure to tuberculosis who is not gaining well at home could be sent to the preventorium.

The most important group of patients is composed of children supposedly infected with tuberculosis at home and whose state of malnutrition is a source of danger. This is the group for which the Preventorium was originally founded and it is

the treatment of these which seems the most important. These undernourished children especially those who have been subjected at home to repeated infection with tuberculosis would be expected to fill some of the beds at the State sanatorium in later years. In bringing them back to a state of good nutrition and strength their prospects are improved. This group I shall take up in greater detail later.

Another group, exactly similar in appearance and in reaction to treatment, is the simple malnutrition group. When for reasons of extreme poverty or bad home conditions a malnourished child does not do well at home he is admitted to the Preventorium. Some children from better homes are admitted and usually do very well, presumably because of improved hygienic conditions and general regulation of dietary and health habits.

Another group, of cases of rickets has, as would be expected, showed excellent results. The combination of good food, plenty of sunlight, with some medical and orthopedic supervision has caused an improvement in many cases that is truly remarkable.

Other types of patients are accepted if there is room and if it seems probable that the out-door treatment will benefit them. We have at present a small group of children with chronic cardiac disease several of whom have recurrent arthritis. We have had single types of many different types of disease and as previously stated we take a few women who are convalescing from various illnesses.

Our cases for 1923 may be grouped as follows:

Malnourished and exposed to tuberculosis...	59
Malnourished but with no known exposure..	61
Convalescents from various diseases.....	26
Cardiac cases .....	5
Rickets .....	5
Tuberculous cervical glands.....	3

Before discussing our cases further a brief review of some recent work in the classification of juvenile tuberculosis may not be out of place. At a meeting of the American Sanatorium Association in December, 1922, a committee headed by Chadwick of Westfield, Mass., gave a report of which I will quote some isolated sentences.<sup>1</sup> "Tu-

<sup>1</sup>Transactions of 19th meeting National Tuberculosis Association, p 447.

berculosis as it is found in children over three and under twelve years of age is a distinctive type in that the lesions are first found in the lymph nodes about the trachea, the bronchi and the large subdivisions." "The Committee therefore recommends that the term 'Hilum Tuberculosis' be added to the present classification." After describing the symptoms of the condition, which in the main were those of malnutrition, the physical signs were stated so briefly that I can quote them verbatim:

"Percussion. Paravertebral dullness—the impaired resonance is found between the scapulae and often extends upward to the supraspinous fossae. Parasternal dullness—this is most frequently found at the right of the sternum and may be erroneously interpreted as due to an enlarged heart.

"Auscultation. Voice and breath sounds are usually normal. Rales are rarely found and when present are usually due to some other cause than tuberculosis."

The X-Ray findings I shall have to omit and proceed to the last two sentences of the report.

"The Pirquet or intracutaneous test must be positive." "All other sources of toxemia or infection that could produce similar symptoms must be excluded before a positive diagnosis of hilum tuberculosis can be made."

In other words, according to this report, our diagnosis of clinical hilum tuberculosis should rest on the following five points: A child that is not well, some dullness on percussion, an X-Ray consistent with the condition, a positive skin test, and the absence of other disease. This report is not acceptable to all. Some experts are doubtful as to their ability to note the interscapular dullness on which the diagnosis largely depends. After a very small experience with this particular point in mind, I am not ready to express an opinion.

A committee of the National Tuberculosis Association in a report which has been generally accepted, has discredited D'Espine's sign as a positive sign of glandular enlargement.<sup>2</sup>

During 1923, fifty-nine of our patients formed the group of malnourished children, either of tuberculous parentage or else otherwise subjected

to contact with active pulmonary tuberculosis. The physical examinations of the chest varied considerably according to the examiner. My examination of these 59 children showed nothing definitely abnormal except as follows,—one child, Leo, showed considerable dullness between the scapulae, some rales, and a positive D'Espine sign. The X-Ray was reported very suspicious and Von Pirquet positive. This child is now at the State sanatorium and is doing well. This seems to be a case of hilum tuberculosis with some parenchymal involvement. Another child, Rita, had a positive D'Espine, and some dullness extending up to the right apex. The X-Ray showed enlargement of the bronchial root glands and peribronchial infiltration. Three other cases could probably be called hilum tuberculosis. The rest of the children in this group gave essentially negative physical examinations. D'Espine's sign was usually negative.

From the above observations it would seem that it is rather uncommon to find obvious physical signs of tuberculosis among children under twelve, even among a group selected in part by tuberculosis workers and drawn from twenty-six malnutrition classes, two large hospitals and the private patients of many physicians in a large community.

These observations on a very small number of cases, are in accord with large series that have been studied. Morse reports that in 1921 in the Medical Out-Patient Department of the Children's Hospital in Boston, the diagnosis on any form of tuberculosis was made less than 100 times in more than 10,000 diagnoses, or in 1% of the cases. In the wards, the diagnoses of tuberculosis in all forms was made 36 times in 822 diagnoses or in 4% of the cases. On the other hand, Kelley reports that in the examination clinics for malnourished children being held throughout Massachusetts, tuberculosis is discovered in 8% of the cases. Obviously these percentages depend on the standard that the examiner has in mind for physical examination, and in the care and completeness of his examination.

In Dr. Chapin's report of deaths in Providence during 1922, 184 persons were reported as having died from tuberculosis in some form. Of these 23 were in the first four years of life and only eight between the age of five to fourteen inclusive. Of pulmonary tuberculosis 141 persons died and

<sup>2</sup>Transactions of 18th meeting of National Tuberculosis Association, p 529.

only one of these was between the ages of five and fourteen inclusive.

A group of 14 malnourished children at the Preventorium recently were selected to note the deficiency in height. Of these children 11 were under 5 years and 3 between 5 and 10 years. They remained at the Preventorium an average stay of nine weeks. In general appearance they were markedly malnourished and considerably underweight for their height. The total gain in weight for nine weeks was 77 pounds, or an average of  $2\frac{1}{2}$  pounds a month. The striking fact about these children was the deficiency in height. The average height for these children figured out accurately from the age height-weight card as furnished by the State Child Welfare Department should have been approximately thirty-eight inches. Their actual height averaged thirty-three inches and the height of the children was on the average approximately five inches less than the average for their age. The growth of these children was an average of 2.2 inches in nine weeks, a gain about six times as great as is normally expected in that period.

Another characteristic of these children has been their mental backwardness or abnormality. They are usually dull, and in school stand below the normal standards for their respective ages. The mental response to improved living conditions is as marked as the physical, and it is nearly the usual thing for a child on returning from Lakeside to go into the class ahead of the children who were formerly with him.

#### *Treatment.*

The first step in treatment has been the making of arrangements for any special procedures that are indicated, such as removal of tonsils and adenoids, treatment of the teeth, examination of eyes, and so forth.

The methods of treatment are naturally of the simplest. We have not sufficient nursing force, equipment, or funds to undertake any procedure that does not promise considerable benefit. The children have a simple diet of cereal, bread and butter, meat, vegetables, fruit, and a quart of milk a day. They have a good sleep at night and a rest period of one hour or more after the 12 o'clock dinner.

They are out of doors day and night in summer,

and during the winter average six hours out of doors unless it is stormy. During about six months in the year the clothing consists of trunks or bloomers with shoulder straps and no sleeves. Thus the legs, arms, shoulders and neck are bare, presenting a considerable surface to the sun. During the winter they wear underclothes, dresses or suits, stockings and shoes. They wear sweaters out of doors if it is cold.

We have not attempted any more exposure to the sun than is noted above, for several reasons. In the first place, any systematic heliotherapy would require considerable oversight and our nursing staff would have to be increased. In the second place, our children are with us only a short time, an average of nine weeks, and there is a constant supply of new patients arriving. It would seem that under these circumstances the objections of the mothers to this form of treatment might be a good deal of a handicap to us. Our chief reason, however, for keeping our children clothed as they have been, is that they have done so well that we have not felt compelled to make any change.

We hope soon to have our piazza on the south partly protected so that the children can have more exposure to the sun in winter.

Tuberculin treatment has not been given. We have not considered it to be indicated for the type of case usually seen at Lakeside.

Practically the only medication given has been cod liver oil and this has been used in the presence of rickets or when the child has not been doing as well as we thought he should.

There is one characteristic of the Preventorium that has, we believe, a beneficial effect on the children, and that deserves special mention. Due to the wise management of the Director, the atmosphere of the place is pleasant. The nurses and employees are happy and enthusiastic and treat the children with affection. Also the children are left as far as possible to amuse themselves in their own way without unnecessary orders or rules. In general the patients are very happy under these circumstances, and it is unusual to find a dopy or unhappy child at Lakeside.

The results of the Preventorium treatment have been so striking that one is tempted to tell about individual cases, but I think that the total weight gained will serve as an indication of the all around



improvement. The total number of children discharged in 1923 was 142. The average stay was nine weeks. The average population at Lakeside was 25. The total gain in weight was 560 pounds, or a quarter of a ton. The average gain was one-half pound per week per child.

### WORK WITH UNDERNOURISHED CHILDREN IN SOME OF THE PUBLIC SCHOOLS OF PROVIDENCE.\*

DR. ELLIOTT WASHBURN

*Executive Secretary, Providence Tuberculosis League.*

Those whose principal work is with the various problems of tuberculosis have become more and more convinced that prevention of the development of tuberculosis is a matter of conserving and building up health in childhood much more than it is a matter of caring for adults who already have the diseases, important as the latter may be in the tuberculosis problem as a whole. Undernourishment in a child undermines its resistance to the infection and development of tuberculosis. Firm in these convictions the Providence Tuberculosis League since 1920 has financially and otherwise actively supported the work with undernourished public school children inaugurated in that year by the Providence Co-operative Nutrition Bureau.

The League considers the nutrition part of its program of work so important that it now provides three full-time, trained nutrition workers, two physicians to make physical examinations, office room, facilities and supplies and is considering adding a fourth nutrition worker. The Nutrition Bureau provides a full-time, trained director of the work.

From a start in one small school the work has steadily enlarged until 51 nutrition classes, each with an enrollment of twenty children, are now carried on in 17 of the large public schools.

The problem set is to determine which children are undernourished, to search out the causes of their condition by physical examinations and by inquiries into their habits and circumstances of living, and, if possible, to remove the causes by

securing the correction of remediable physical defects, and the correction of non-physical faults through individual and class teaching and training in nutrition classes and by intensive follow-up, home visiting without which latter much of the labor would be wasted because a backward pull in the home easily overpowers a forward pull in the nutrition class.

#### *Which Children Are Undernourished?*

The assumption that all children who fall seven per cent. or more below certain height-weight standards are undernourished is not founded on authority. Racial characteristics, heredity and other important factors enter and must have due consideration. Numerous healthy and sufficiently well nourished children are below the standard weight. Conversely, some overweight children are not well nourished. Because a child is not seven per cent. or more underweight it by no means follows that he is healthy. In a recent study of 4000 Italian children from two to ten years of age Dublin, statistician of the Metropolitan Life Insurance Company, found that when the scales are used to separate the well nourished from the poorly nourished many malnourished children are missed, and in Italian children from six to ten years old the scales miss about two-thirds of the poorly nourished. This discrepancy is less marked with native born American children. Notwithstanding these truths, some handy rough-index of undernourishment is necessary in our work and we have found the seven per cent. underweight rule the best available, certainly the most convenient ready method in the initial separation of the undernourished from the well nourished. Physical examinations, not always available, alone can definitely determine whether a child is underweight, undernourished and unhealthy, or simply underweight but sufficiently well nourished and healthy.

Recently a large special committee issued new weight-height-age tables which agree that after eleven years of age, age must be taken into consideration as well as height in judging average weights of children. The tables also take into account certain types as "short," "medium" and "tall," allowing zones for each type. These tables are based on a study of 74,000 boys and 55,000 girls. In taking weights and measurements of

\*Read before the Providence Medical Association, February 4, 1924.

children accuracy is of the first importance. This committee on tables placed the standard of underweight at six per cent. for children six to eleven years of age. According to this any child six per cent. underweight for height between these ages is considered a subject for special study, examination and treatment. After the age of eleven age must be taken into consideration. Hence the name "weight-height-age" tables.

All nutrition workers have found, as we in Providence have found, that there are seasonal and vacational variations in weight. Here we have found the period of greatest increase in weight to be from October to January and the period of least increase between April and July. Baldwin says, "No one knows the exact seasonal and vacational variations; too many factors are involved."

Of 4700 children weighed in 17 of our public schools by our nutrition workers during the fall of 1923 a little less than 25% were in the seven per cent. or more underweight class; 1100 children in round numbers. These 1100 are the children from whom our 51 classes are made up at this time.

#### *General Plan of the Work.*

(1) Securing the weighing and height measurements of the children.

As we work with very close measurements accuracy must be assured. This is secured by uniformity in methods of weighing and measuring by having our own workers do all the weighing and measuring in the schools where we work.

(2) Grouping all those seven per cent. and more underweight as per the tables of weights, heights and ages.

This is a matter of computation and separation.

(3) Obtaining the permission of parents or guardians for the physical examinations of the underweight group.

Ours is a non-official work. We have no legal right to examine a child without permission of those legally responsible for the child and no examination is made without such prior permission. It is obtained by letters and by personal visits to the homes.

(4) Physical examinations by the physicians.

At these examinations the nutrition workers are present as well as many of the parents. On a

special record card are noted the defects found and other important facts developed by questioning, and also the recommendations of the physician.

(5) The physical faults and defects found are brought to the attention of parents or school physicians and nurses or the family physician as the case may be.

(6) The formation of nutrition classes, averaging 20 children to a class, for instruction in food and health habits by the nutrition workers.

Each class holds a half-hour session, in school hours, every week. Every effort is made to encourage the attendance of parents also at these classes. At every session the children are weighed and measured and these data recorded on a special follow-up card.

(7) Follow-up work by the nutrition workers.

The purpose of this is to ascertain at first hand the actual living and home conditions of the children, their habits and the circumstances peculiar to each case and to secure and hold the co-operation of parents in correcting physical faults and incorrect health habits of the children.

Since the work started 1857 have been in the nutrition classes for varying lengths of time. Of this number, 695 have had at least one physical examination by a physician on our staff. A considerable number have had repeated examinations when they appeared to be expedient. These examinations have been as thorough and as comprehensive as the circumstances under which they were made permitted. Thus no child was stripped below the waist line and no abdominal examinations were attempted because we did not wish to stir up opposition by parents. The remainder, or 1162 children, were not examined by our physicians although many of them received the regular examinations of the school physicians, in the first, middle and graduate grades of the primary and grammar grades.

The need and value of intensive physical examinations at the very start of nutrition work is perfectly obvious. Revealing and correcting physical defects leaves the child "free to gain" at least so far as physical causes of its undernourishment are concerned.

The number of defects and physical faults disclosed by the examinations is always large. Indeed, the child in our groups who did not have



at least one physical blemish was very much a "rara avis" although to be sure many of the defects were of a minor nature and could not be truly classed as "outstanding physical defects." Yet it is true, in many of the children the existence of not one alone but several and often many minor defects created a condition of physical inferiority which was considered sufficient cause for their undernourishment.

A "control" of our work by similar examinations of a like number of children who were not undernourished would have been of much value but was not feasible with the limited resources at our command.

A resume of the physical defects and conditions of ill health found in the 700 children examined is of interest.

Carious teeth, ranging from one to 14, in 366 children.

Tonsils, not healthy, in 215 children. In 136 children the tonsils had been removed.

Mouth breathers, probable adenoids, in 122.

Cardiac conditions: Organic lesions in 30; functional murmurs in 28; marked arrhythmia in 12; impure sounds in 17; cardiac and renal disease in one.

Thyroid enlarged in 32, of which two were very large.

Anterior cervical glands enlarged in 109, posterior cervicals shotty in 131, maxillary in 19, epitrochlear in one. The large number who had shotty posterior cervical glands was surprising and the writer is not sure of their significance.

Neck scars, the results of broken down glands, in 11 children.

Pulmonary conditions: Four children were sent to Wallum Lake as being undoubtedly actively tuberculous. In eight there was evidence of old, inactive pulmonary tuberculosis. In 44 the combination of physical findings and clinical condition warranted the diagnosis of probable hilum tuberculosis. Forty-eight children were in that class which the reader calls "suspicious of but not proven tuberculosis." Some of the children in this last group have now been under our observation for three years. The reader believes that some of this group will some time and some where become definitely and provably tuberculous. In 115 other children there were marked variations from the usual percussion, and auscultation signs with-

out any especial evidence of pulmonary disease. Sub-acute bronchitis present in 5; chronic bronchitis in 15; asthmatic bronchitis in 5; apparently not fully resolved pneumonia in 3; post-influenzal conditions in 5; while acute colds were very numerous.

Nasal conditions: Deviated septum, varying from slight to complete occlusion, 53; enlarged turbinates, 4; nasal polyp, 1; frequent profuse nose bleed, 3; syphilitic nose, 1; profuse nasal discharge, 52.

Throat conditions: Chronic hoarseness, 3; growth in pharynx, 1; syphilitic throat, 1.

Aural conditions: Deafness, 8; purulent discharge, 10.

Anaemia, marked, 6.

Cutaneous conditions: Scaly skin, 2; eczema, 9; ring-worm, 3; scabies, 7; furunculosis, 3; acne, 4; impetigo contagiosa, 3; rash of undetermined nature, 1; psoriasis, 1; vermin, not infrequent.

Acute contagious disease: Measles, 1; scarlet fever, 1.

Orthopedic: Curvature of the spine, more or less, 14; tuberculosis of hip, 1; chronic arthritis, 1; chest deformities, 4; extreme round shoulders, 8; extreme flat foot, 1; spina-bifida, 1; birth paralysis, 1; post infantile paralysis, 9.

Miscellaneous conditions, 99; including chorea, 14; marked mental dullness, 18; haemophilia, 1; fracture of the clavicle, recent and untreated, 1; probable epilepsy, 3; frequent headaches, 1; hernia, 4; hydrocephalus, 1; marked neurotic conditions, 21; tuberculous peritonitis, 1; rickets, 5; marked strabisms, 4; and chronic constipation and stomach disorders.

In 125 of those examined the fault found did not constitute an outstanding physical defect.

With those children who did not receive the special physical examination because of the small size of our examining force we were distinctly handicapped by the lack of such examination. There can be no question that the attempt to remove undernourishment without complete physical examinations is a good deal like guessing the color of a cat in a bag. It may be done but it is uncertain at the best.

Correction of physical faults, teaching, training and observation in the nutrition classes by trained nutrition workers, home-visiting and correction of faulty habits and home conditions bear-

ing on nutrition; these are the agencies employed in our work.

Since January 1, 1921, work has been carried on in 137 classes in 18 schools with 1857 children of whom 695 have had the special physical examination and 1162 have not. Of the total number of children 576 have graduated from the nutrition classes because they have come up to average weight; 770 are still in classes; and 511 had not come up to weight at the time they left classes. The reasons for leaving the classes before coming up to weight were as follows: Graduated from school, left school, moved to other schools, discharged from classes for disciplinary reasons, taken out of classes and put under doctor's care, parents refused to allow them to continue in classes, expelled from school, transferred to special schools, transferred to fresh air schools, sent to state sanatorium, classes discontinued, sent to preventorium, died. In the school year 1922-1923 the average gain per pupil in nutrition classes, per week, was 2.16 ounces as against the general average gain of all children of 1.95 ounces per week. We have charts showing most surprising gains in weight following the removal of diseased tonsils.

As distinct from physical causes the following were the most commonly observed factors in the production of undernourishment in our children: Improper food—this was very frequent; bad breakfasts, coffee and cake, coffee alone, and sometimes no breakfast at all; too late to bed, insufficient sleep, very common; overactivity, both physical and mental, very common; unfortunate home economies, such as food poorly chosen and improperly prepared by young persons because the mother works out; conditions of general discouragement and don't care seen occasionally in some mothers hard hit by the vicissitudes of life; too much candy, pie, cake; too little of proper food; a contributing factor was the lack of interest shown by some parents in what the school and our workers try to do for their children. It is worth noting that instances of undernourishment due principally to an insufficient amount of food, or starvation, were extremely rare in spite of the fact that our work was with children of many and varied races and economic conditions.

It must be borne in mind that in many cases one or more of these home-factors operated in con-

junction with one or more outstanding physical faults, the grand total being sufficient to produce the undernourished condition. Other less common causative factors were lack of home control, too great stress of school life, skipping grades.

The failures to gain weight were as a rule due to failure to secure the correction of physical faults, to lack of co-operation of parents with our workers and to persistence of the various home factors just enumerated. Our best gains have been where the co-operation by the parents was good; our worst results where there has been little or no co-operation. The economic conditions prevailing in some homes are hard to combat and almost impossible to overcome.

The whole problem is largely physico-social in its nature.

The correction of remediable physical defects is important but of equal importance is the correction of faulty home factors. Through reference of children to physicians, school physicians and nurses, and through them to dental, aural, throat and nose, pulmonary, cardiac, orthopedic, skin and other clinics, to hospitals, preventorium and sanatorium many have been helped. By class teaching of the child and by intensive visits to homes our workers have often been able to secure the correction of untoward influences. The home influence outweighs the influence of the classroom and will turn the scale for or against the success of such work as this. Hence it is vital to secure the co-operation of the home in every possible way.

One cannot make, with accuracy, a hard and fast statement of the exact value of this work but it is true that it is the kind of work that should and undoubtedly will bear very valuable results in the future. The introduction of nutrition work as a part of a division of health education of public school departments is greatly to be desired. This has been done by the city of Rochester with notably good results. The time to prevent tuberculosis is in childhood. Nutrition work in all schools, however those schools are supported, is one of the most valuable and practical methods of reaching children at our command at this time, and if it can be conducted on a large enough scale should go far toward reducing the morbidity and mortality of tuberculosis and incidentally of other diseases as well.

# DISCUSSION OF PAPERS OF DRs. WASHBURN AND BUFFUM.

DR. PERKINS: I would like to call the attention of the Society to the attitude of the Anti-Tuberculosis League in its work, and that is that the ones with whom we can accomplish the most are children. It is concentrating its work now largely upon children, the nutrition work in the schools and the Lakeside Preventorium. The work at the Preventorium is the same kind of work in the Summer season, the regular outing work. Miss Murray selects those cases that need the outing the most. She does not take them in the order in which the names are put in, and the work is carried on practically. Simply to hear a paper does not give you any good idea of what is back of it. Statistics are hard to understand. If you will read them when they come out in the MEDICAL JOURNAL, you will agree that we are doing work that is well worth printing.

\* \* \*

DR. WASHBURN: I would like to say to the members present that the League conducts for the Providence physicians consultation service which is free to any physician who wants to use it. Any physician in the city who desires help in the matter of diagnosis or in the matter of disposition of a patient at a sanatorium here or anywhere in the country has but to come to the office and that help and information will be given.

\* \* \*

DR. CORVÈSE: When we think what can be done for the children, and that the city is contemplating spending \$200,000 for a golf course, it seems to me that if they would spend it for the children it would be much more worth while than for a golf course.

## THE PROSPECTS FOR HELPING PSYCHO-NEUROTICS.

BY DR. H. B. SANBORN,  
PROVIDENCE, R. I.

The psycho-neurotics are ever with us, forming a considerable percentage of the total number of our ill. What are we doing for them? How many of them are we curing? By what means can we hope to most help them?

The psycho-neuroses include four main sub-

divisions: neurasthenia, hysteria, anxiety neurosis and compulsion neurosis—all functional diseases more especially and primarily of the nervous system but showing very manifold symptoms both mental and somatic; there being no organ in the body whose function is not liable to disorder.

They all have the characteristic also, of being not directly or consistently amenable to any form of therapy except psycho-therapy, it being well proven that wherever there has been improvement under treatment, this has been chiefly due to a psychic effect. This fact is in perfect harmony with the result of various investigations which show the cause of these disorders to lie in the mind or psyche. When we speak of mind in this connection we must remember that the mind includes an affective or emotional field as well as an ideational field, and also that those mental contents of which we are conscious form but a comparatively small part of our mind; the larger part being subconscious or unconscious.

People with psycho neuroses are seen and treated by physicians in all fields—general practitioners and specialists in all lines; also by healers of all cults and kinds. Of physicians, the general practitioner is first consulted by the majority of psychoneurotics; some at once consult the specialist who treats that particular part of the anatomy which the patient feels primarily at fault; comparatively few go to the nerve specialist. Whoever sees them sees a certain proportion of them get better, apparently helped by whatever the method of treatment employed; these have faith that the cause of the trouble has been found and the proper remedy applied; this is a favorable mental attitude, and time and nature does the rest. Many others, however, do not get well in the hands of the first physicians but go to others who do seem to effect a cure. This is generally due to chance or special favorable circumstance. For example, if Mrs. Jones has the preconceived idea that her trouble is seated in her gastro-intestinal she is more susceptible to help from the physician who holds the theory that most troubles are due to gastro-intestinal intoxication and who accordingly takes a radiograph of her gastro-intestinal tract, demonstrates a slight ptosis and assures her she will be cured by wearing a belt. Rarely the reason for one physician curing where another has failed is really due to a better understanding



of the disease, and the employment of more rational treatment. Other psychoneurotics seem to get no appreciable or lasting help from any physician or any healer outside of the medical profession but drift hither and thither in search of cure or give up in despair.

Of those who get better how many do not soon either suffer a recurrence of their old symptoms or else new symptoms of the same old psycho-neurosis? Very few, but yet some of them, and I believe the number is now increasing from year to year. During the past decade marked progress has been made in gaining an understanding of the true nature of these diseases. This has come through a study of the whole life of the psychoneurotic, especially the emotional life and the content of the subconscious mind. The chief means of exploring the subconscious mind have been: hypnotism, automatic writing and psycho-analysis which includes a study of the dream life as well as the mind awake. The result has been to show that all psychoneuroses are brought on by a faulty adjustment of the individual when one of the two strongest and most primitive instincts of life meets with opposition. These two instincts are: the instinct to preserve the individual's life and the sex instinct which latter covers a great number of instinctive activities concerned with mating and the rearing of offsprings.

It has been found that a psycho-neurosis is seldom if ever really due to one single event or circumstance in the life of the individual, but rather to a series of faulty reactions dating back to childhood, and for these faulty reactions it now appears that early environment is more to be blamed than heredity. But as Jackson and Salisbury put it in their little book entitled "Outwitting Our Nerves": "As a matter of fact, it seems to take a number of ingredients to make a neurosis,—a little unstable inheritance plus a considerable amount of faulty upbringing, plus a later series of emotional experiences bearing just the right relationship to the earlier factors." These faulty reactions of earlier life seem to consist of the clinging too long and too strongly to certain emotional reaction which for a certain stage in our development are perfectly normal. The above quoted authors name four childhood habits which particularly seem liable to become too firmly fixed, i. e., to persist into later life with too much intensity and

form a source of nervous sickness. They are: (1) The infantile phase of the love emotion, (2) the habit of rebelling, (3) the habit of repressing normal instincts, and (4) the habit of day dreaming. In each case it is the excess of feeling which causes the trouble. We can say that most all neurotics are over sensitive to their feelings and so feelings rather than reason become the dominant force in their lives. I might add here that all of us are guided in our actions much more by emotion and much less by reason than we realize.

As I have already intimated, the only rational methods of treatment of these disorders are those which recognize the psychic origin of them and which tend to either remove or offset the injurious mental factor. To again quote Salisbury and Jackson, "These methods may be classified into two groups. The first group includes those methods, hypnosis and psycho-analysis, which make a thorough search through the subconscious mind for the buried complexes causing the trouble, and might, therefore, be called 're-education with subconscious exploration.' The other group includes so-called explanation and suggestion, or methods of 're-education without subconscious exploration,' which content themselves with making a general survey and building up new complexes without going to the trouble of uncovering the buried past. Although the theory and the technique vary greatly, the aim of all these methods is the same,—the readjustment of the individual to life."

To really effect a cure of a deeply rooted psycho-neurosis by any method is a very time-consuming process and requires an understanding on the part of the physician, of the factors which in general are responsible for such a condition and some skill in the practice of the particular psychotherapeutic method which he employs. This means that for many years to come the number of those physicians trained to cure such cases will be so inadequately small and the number of sufferers so large that but comparatively few of the latter will be cured. This belief leads us to realize the importance of attempting steps to check the development of so many cases. Such prophylactic steps must, I believe, consist in spreading first a much deeper and more general understanding of these diseases and their causes among physicians and teachers and then with their help educating

the people at large to remove the harmful environmental conditions which are now active in the lives of so many children and to avoid the formation or fixation of those mental habits which we know are particularly dangerous, substituting for them a truer view of life, more healthful mental attitudes, and habits and better control of the emotional side of their lives. Some such a program is bound to be an important part of the general program of mental hygiene which is now getting under way. I believe we can hope for the time to come when there shall be such a general and true understanding of these psychic mal-adjustments and how to avoid them that psycho-neurosis will be then one of the rare diseases instead of, as now, the most common.

### ANNOUNCEMENTS

#### THE STATE SANATORIUM.

In 1923, the number of patients admitted to the State Sanatorium in the Minimal and Moderately advanced groups together was 153, while 263 patients had far advanced disease.

We appreciate that it is the impossibility of persuading many consumptives to give up their work at the onset and take Sanatorium treatment, which accounts for the admission of many far advanced cases.

It is also true that many reasonable patients come to us in the far advanced stage, because of long delay in diagnosis.

There are many patients with negative sputum in whom the signs and symptoms are suspicious of tuberculosis, but too indefinite for prompt diagnosis. In many such cases the X-ray furnishes evidence which establishes the diagnosis. About two-thirds of our negative sputum patients have had no X-ray examination previous to admission. During 1923, physicians sent 72 patients to Wal-lum Lake for X-ray of the lungs.

The time has come when all negative sputum patients with signs or symptoms which are suspicious of tuberculosis but insufficient for diagnosis, should be promptly X-rayed.

The Trustees have authorized me to offer to all physicians of Rhode Island, free X-ray examination on suspected patients, who in the opinion of their physicians are unable to pay the customary X-ray charges. Reports of X-ray findings will be sent to the physician who recommended the case.

Physical examination will also be made and reported to physicians who desire it.

Patients may come to the Sanatorium for X-ray Monday and Thursday mornings. We have quite occasionally found that patients who will not consider admission to the Sanatorium, will go to Wal-lum Lake for X-ray pictures, and after seeing the institution, are willing to return there as patients.

The Sanatorium is taking films of about 700 different cases of pulmonary tuberculosis yearly. Specializing in chest work, and with good equipment, we are able to take high grade stereoscopic lung pictures and have both film and fluoroscopic interpretations made by those who frequently check their X-ray and physical findings by necropsy.

We hope that this offer may result in the Sanatorium rendering more and better service to the medical profession and to the tuberculosis patients of Rhode Island.

H. L. BARNES, M.D.

*Superintendent*

#### A PROVIDENCE MAN HONORED.

DR. ISAAC GERBER of Providence has received an unusual honor from the trustees of the Boston City Hospital. He has recently been appointed as assistant in the X-ray department of that institution, and is to have charge of a new sub-department of Radiation Therapy. This department is to be newly equipped and reorganized, and will have quarters in the recently dedicated Thorndike Memorial Laboratory. Here all types of X-ray treatment will be employed, including both superficial and deep radiation. All the radium treatment of the hospital will be administered through this department. Not only will the usual radium salts be utilized, but in addition there will be provision for the use of radium emanations wherever indicated. Opportunities will also be available for the use of electro-desiccation and electro-coagulation, which have been found of extreme value as adjuncts to the other methods of radiation treatment. This is the first clinic in New England where these electro-thermic methods will be used to any extent. Besides it will be the first hospital department in New England in which all the methods of radiation treatment will be used in combination, and under the direction of a radiologist.

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**Section on Medicine**—4th Tuesday in each month, Dr. Charles A. McDonald, Chairman; Dr. C. W. Skelton, Secretary and Treasurer.

**R. I. Ophthalmological and Otological Society**—2d Thursday—October, December, February, April and Annual at call of President Dr. F. Nolton Bigelow, President; Dr. Jeffrey J. Walsh, Secretary-Treasurer.

**The R. I. Medico-Legal Society**—Last Thursday—January, April, June and October. James B. Littlefield, Esq., President; Dr. Jacob S. Kelley, Secretary-Treasurer.

## EDITORIALS

### WHAT ARE OUR IDEALS?

It is said that in many of our rural communities there is a shortage of doctors; that most of the doctors, especially the younger ones, want to get in the city where they will have more advantages. It is also said by the public that it is often difficult to get doctors and nurses to go out on cases, even serious ones, at night, and that both the doctor and the nurse are loath to take certain types of cases, even though the respective nurse and doctor is not a specialist. Is it not true that the medical and

nursing profession faced his question frankly and endeavored to determine whether criticisms which have been directed toward them are in any measure justified? And is it not possible that we have been caught, especially the younger generation, in the wave of selfishness that seems to be so prevalent in the world? Among the younger generation of physicians we notice this tendency manifest even in their hospital service—where some of us used to think there were not enough hours in the day to take advantage of all the opportunities presented us—we now see the internes expecting at least one whole afternoon off every week, and in



some places a week-end comes rather frequently. And no matter how interesting a case or instructive a clinic may be going on, the young doctor must have his afternoon off. Of course, we have no brief against a proper mixture of work and play, but in the old days, an acquiring of useful medical knowledge did not seem to be a hardship, and interesting new cases were a mental as well as physical tonic which could not be replaced even by our hours off duty. Our profession has always been one whose aims and ideals have been of the highest, our lives supposed to be devoted to the service of humanity; is there not danger, as is clearly evident in the world at large, that we are becoming too self-seeking? Medicine has for many generations held too honorable a place in the public esteem to risk losing our position in the firmament of humanities through our own selfishness, and we should face this matter frankly before it is too late to retrace our steps.

#### OSTEOPATHS.

Some years ago the General Assembly of Rhode Island passed a law recognizing osteopaths and providing for their registration. Under the law the State Board of Health was charged with the duty of examining them and issuing their licenses.

In the law, osteopathy is defined as healing by "manipulation," otherwise they are given the same privileges as regular physicians. The law does not specify any limitations and the osteopath can now legally put up his sign "osteopathic physician" and treat any person in his office or the home. He is also permitted to sign death returns. In the past, however, he has had few occasions because people call in a regular physician if they become seriously ill or the osteopath has referred seriously ill patients to a regular physician. What few deaths have occurred in his practice, he has asked some regular physician to sign the return because he probably did not know enough about disease to make a diagnosis.

Previous to the passing of the licensing law the osteopath confined his attention to mild and chronic conditions. Recently, however, since a certain number of osteopath schools have been endeavoring to put into their courses the subjects taught in regular schools, osteopaths have become bolder and are treating almost anyone who applies to them. One hospital has recently had the experi-

ence of having two patients suffering from scarlet fever referred by two different osteopaths. Another hospital which treats mental diseases was asked to admit a patient suffering from some mental condition.

The following quotation is taken from a letter written by an osteopath who was himself a patient in the hospital and whose letter-head reads "Dr." So-and-So. "If I am not mistaken registered physicians are not charged for services rendered them in your hospital. Consequently, I do not understand why such a statement should be sent me, for as you must know, I am a registered physician with the State Board of Health."

It is perfectly obvious that the osteopath is perfectly within his rights when he offers to treat patients suffering from an acute or chronic disease or from injuries, so long as his treatment is confined to manipulation.

The law directs the State Board of Health to select three examiners, who shall pass upon their qualifications, and one of these examiners must be an osteopath. The law does not stipulate what the examinations shall cover, that matter being left to the discretion of the State Board of Health. That Board does examine osteopaths upon certain subjects requiring knowledge about the human body and the clinical manifestations of disease, but it is not the same rigid examination required by the regular practitioners. The State Board of Health is unfairly discriminating between the physician and the osteopath, both of which are given the same privileges.

There are three ways this situation may be met. First, the law regulating the osteopaths may be repealed.

The second is to pass a new medical practice act specifically requiring all who appear before the State Board of Health to undergo a written and practical examination to determine whether they are capable of knowing how to make diagnoses and let each practice what he chooses.

Even if a new act is not passed, it would seem as though the State Board of Health had the power to require the same rigid examinations of osteopaths as is demanded of regular physicians.

The physicians of Rhode Island should and can if they so desire have this state of affairs corrected, to do justice to themselves and protect the public to the extent of not allowing the State of

Rhode Island to put their stamp of approval upon imperfect equipment.

#### THE STUDY OF MEDICAL HISTORY.

In one of his addresses, Dr. Oliver Wendell Holmes urges his hearers not to look with contempt on their old medical books: "The *débris* of broken systems and exploded dogmas," he continues, "form a great mound, a Monte Testaccio of the shards and remnants of old vessels which once held human beliefs. If you take the trouble to climb to the top of it, you will widen your horizon, and in these days of specialized knowledge, your horizon is not likely to be any too wide." On every side we hear complaints that our modern physicians are too frequently neglecting the broad general knowledge of their profession and are devoting themselves to the study of this or that special department of practice, the result being, we are told, that we are failing to see the forest because of our sedulous contemplation of the trees. Of course, one must not make too much of these complaints, for time out of mind, someone has been finding fault with our profession, and we have become, if not fatigued by them, at least tolerant of our critics. But if we are, in truth, tending to cultivate intensive rather than extensive knowledge and experience, then indeed do we require a remedy, than which there is none better than the study of medical history.

To watch the birth and growth of medical thought, to study the rise and fall of systems and the conflict of ideas, to observe our medical forebears struggling to emerge from the mists of ignorance to the bright light of knowledge, to rejoice with them in their successes and to deal gently with them in their failures, to draw inspiration from their labors, courage from their heroisms and support from their moral grandeur—these are things which are good, surely, for any man who desires to uphold the honorable traditions of his calling. Who can read, even cursorily, the writings of Hippocrates without absorbing something of his intellectual honesty and sincerity of purpose? Nowhere will you find a better example of the lucidity, directness and originality of Hellenic thought. In Galen one may study the pernicious influence of speculative philosophy on anatomy, physiology and even practical medicine,

but in extenuation of all this, one discovers the beginnings of experimental physiology in a series of really remarkable researches upon the structure and functions of the different organs of the body. The Byzantine and medieval physicians pass before us to warn us against a too docile reverence for authority—a reverence which, because of the sterility of mind it produces, proves our indefeasible need of thinking for ourselves. Then come the physicians of the Renaissance, the medical humanists, harbingers of the dawn, a grave and honorable company who drank again out of the springs of Helicon, and taught their young successors out of Hippocrates and Galen to study, not books, but Nature herself. Among these young men was Vesalius, whose inquisitive scalpel cut the bonds of immemorial Galenism, and made Harvey, Sydenham, Laennec, Pasteur, Lister and us, possible.

Such is our heritage: can it be that any of us, aware of his more than regal lineage, should be content to leave it without the circle of his interests? The difference between us and irregular practitioners of whatever stripe is this, that having no roots in the past, they hold no promise for the future. Born of the present, they have their little day and cease to be, while the profession of Hippocrates shall continue to minister as long as men require their service. To read the history of medicine is to become conscious of our treasures, and if, perhaps, we have no power to augment them, we shall, at the very least, strive to prove ourselves their worthy custodians.

#### PRE-OPERATIVE ESTIMATION OF SURGICAL RISK.

The dangers to be apprehended from a surgical operation fall into three classes:

First, those pertaining to the definite pathological condition for the relief of which the operation is performed.

Second, those referable to faulty technique.

Third, those depending upon some pathological condition in the patient, in no way connected with the reason for operation, but greatly increasing the risk from anaesthetic or operative procedure.

Most operators spend much time and care in minimizing the first two classes of risk, but an amazingly large number of otherwise competent

surgeons bring their patients to operation without adequate investigation of all the risk involved.

When a patient is operated on for an interval appendix and dies from acidosis due to a precedent diabetic condition, that patient's friends have a right to ask why the condition was not known before operation and proper measures taken to protect the patient from that entirely unnecessary extra risk.

Even in emergency cases, when operation is imperative, a careful survey of the situation as regards heart, lungs and kidneys will indicate the anaesthetic of choice, minimizing the inevitable risk.

Every patient brought to the operating table is entitled to the maximum protection possible. This he does not get in the absence of a thorough medical examination before the operation.

### SOCIETIES

#### PROVIDENCE MEDICAL ASSOCIATION.

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. George W. VanBenschoten, Monday, March 3, 1924, at 9:00 P. M. The records of the last meeting were read and approved.

The President appointed as members of the Child Welfare Committee: Ellen A. Stone, Chairman, William P. Buffum, Jr., George T. Spicer.

The President announced the death of Dr. Norton Bigelow, and appointed as a committee on a memorial: N. Darrell Harvey, Chairman, L. B. Porter, Halsey DeWolf.

The first paper of the evening was by Dr. Albert H. Miller on "A Blood Pressure Paradox," where the diastolic reading apparently is at zero. The explanation is that the diastolic reading should be at the fourth phase, but this is usually so short that many take the fifth phase, where all sounds cease. In two thousand cases, Dr. Miller found twenty-two where the fourth phase continued down the scale to zero. It has been noted most often with aortic insufficiency, exophthalmic goitre, and fracture of the skull, and especially frequently with general anaesthesia. Apparently this condition did not seem to influence recovery.

As the second paper of the program, Dr. Alex. M. Burgess presented in an interesting, graphic manner a number of cases of severe diabetes treated with insulin. Although all these cases had

been practically *in extremis*, they were shown in good condition, though four of them were to all intents without pancreatic function and on increasingly large doses of insulin.

Dr. A. A. Horner of Boston read a paper on the "Routine Treatment of Diabetes Mellitus." He stressed the prevention of obesity as a prophylactic, especially as age advances, and urged routine urine examinations. Although not advising insulin in all cases, he thought it necessary in patients under thirty, all those not sugar-free on a test diet, and in cases complicated by acidosis, fever, high pulse, infections or surgical operations. The problems of diet were discussed in a general way, and it was advised that patients should receive a diet sufficient to keep them happy and strong, supplemented by insulin to keep them sugar-free. Dr. Horner illustrated his remarks with diet lists which he distributed.

The discussion was opened by Drs. DeWolf and Westcott, followed by Drs. Fulton, Mathews and Horner. A vote of thanks was tendered Dr. Horner.

After remarks by Dr. Utter, it was voted that the President appoint a committee to consider the question of a Medical Milk Commission.

The meeting adjourned at 10:45 P. M. Attendance, 80 members, 10 guests. Collation was served.

Respectfully submitted

PETER PINEO CHASE, *Secretary*

### HOSPITAL NOTES

#### CITY HOSPITAL.

Doctors Cecil C. Dustin and Joseph P. Nourie finished their interne services on April 1st and the former begins his service at the Rhode Island Hospital, while the latter returned to complete his service at the Rhode Island Hospital.

Doctor Earl F. Kelly, the third interne to complete his service, has gone into private practice in Pawtucket, specializing in Pediatrics.

Dr. Julius A. Olean commenced a service on March 1st and Dr. William J. Sheehan on April 1st.

The present outbreak of scarlet fever has been so widespread that in order to accept all who desire hospital treatment, it was first necessary to discharge the patients who were suffering from venereal diseases and later to send home or transfer the patients suffering from tuberculosis. In



spite of this, the hospital has been crowded but up to date no one suffering from acute diseases has been refused.

## MISCELLANEOUS

### THE NATIONAL MANIA.

One advertisement of bran claims that the preparation, served on cereal, is "Good as a Daily Dozen." A man from Mars, or even perhaps from Europe, might wonder why being as "good as a Daily Dozen" is recommendation for bran, and, if it is only as good as the Daily Dozen, and not better, why the prospective consumer might not choose the Daily Dozen.

But for Americans, the advertisement need be no less subtle. When the stream of business men driving to their offices are confronted by such billboard advertising, they know that it refers to the national malady, constipation. And they know that the Daily Dozen (the setting-up exercises which they use as remedy) take all of ten, fifteen or twenty minutes, minutes which may make them late to the office. They know too that it is more work to exercise than to eat bran. Thus the American love of ease and of the labor-saving device assures that between bran and calisthenics, the prospective consumer is not apt to choose calisthenics.

The advertisement is a clever exploitation of our national mania for shortcuts—anything that is a little easier, that will save three minutes. Apparently we have an inherent inability to learn how seldom we get more than we pay for.

It is not the purpose of this editorial to denounce bran. The man who eats it is just that much to the good, but he could well afford to indulge in the Daily Dozen as well. Bran will, in many cases, relieve constipation, but it does not build up muscle and send the blood racing. Only exercise will do that.

The situation is made even more humorous because the Daily Dozen is in turn a short-cut, an effort to condense into twenty minutes an amount of exercise which on the ball ground, golf links, hockey field, tennis court, bridle path, swimming pool or skating rink, might take two hours, allowing for time spent in changing costumes and in transportation.

But something may be missing even though every muscle of the body is given fastidious grooming. Enjoyment of the outdoors and the colorful costumes of players, the exhilaration of competitive sports, the pride in skill, the spirit of play and the sense of change from an indoor environment, all play their part in keeping a person fit. Take these away and you are running the business of your health on too narrow a margin. Soon interest flags, enjoyment pales.

The sportsman has been reduced to a braneater.—*Hygeia*.

### NATIONAL COMMITTEE FOR MENTAL HYGIENE.

Dr. Frankwood E. Williams was re-elected Medical Director of the National Committee for Mental Hygiene at the annual meeting of the Board of Directors, held in New York City, on December 28. The following were elected members of the Executive Committee: Dr. William L. Russell, Medical Director, Bloomingdale Hospital, White Plains, New York; Dr. Walter E. Fernald, Superintendent, Massachusetts School for the Feeble-minded, Waverley; Dr. Stephen P. Duggan, Director, Institute of International Education, New York City; Dr. William A. White, Superintendent, St. Elizabeth's Hospital, Washington, D. C.; Dr. Charles P. Emerson, Dean of the Medical School, University of Indiana, Indianapolis; Dr. C. Floyd Haviland, Chairman, State Hospital Commission, Albany, New York; Dr. Arthur H. Ruggles, Superintendent, Butler Hospital, Providence, Rhode Island, and Mr. Matthew C. Fleming, attorney, New York City. Dr. William H. Welch, president of the National Committee for Mental Hygiene, presided.

(From News Bureau, Ambassador Hotel.)

Atlantic City, N. J., March 8.—The American Climatological and Clinical Association will meet at the Ambassador, Atlantic City, for its annual convention, May 1-2-3. One hundred fifty doctors are expected to attend.

The American Urological Association has also completed arrangements to return to the Ambassador where it met two years ago. This association will spend two days at the shore, June 3 and 4.

# What is S. M. A.?

S. M. A. is an adaptation to breast milk which resembles breast milk both physically and chemically.

S. M. A. in addition to giving excellent nutritional results in most cases, also prevents nutritional disturbances such as rickets and spasmophilia.

S. M. A. requires no modification or change for normal infants. As the infant grows older the quantity is merely increased.

S. M. A. requires only the addition of boiled water to prepare.

(Orange juice, of course, should be given the infant fed on S. M. A., just as it is the present practice to give it to breast-fed infants.)

## Why was S. M. A. developed?

Because there is a real need for an adaptation to breast milk which will give satisfactory nutritional results in the great majority of cases, which includes the preventive factors, and which is, at the same time, so simple

to prepare that the physician can rely on the mother to follow his directions accurately.

## How is it possible to feed S. M. A. to infants from birth to twelve months of age without modification or change?

The answer to this question sounds the keynote of the success which thousands of physicians are having with S. M. A. It is not necessary to modify S. M. A., for *the same reason that it is not necessary to modify breast milk*:—for S. M. A. resembles breast milk not only in its protein, carbohydrate and salt content, but also *in the character of the fat*. Since the very young infant can tolerate the fat, as well as the other essential constituents in S. M. A., it is possible to give this food in *the same strength*, to normal infants *from birth to twelve months of age*.

As the infant grows older, therefore, it is only necessary to increase the *amount* of S. M. A.



Samples and literature to physicians on request.

S. M. A. is to be used only under the direction of a physician. For sale by druggists.

Formula by permission of The Babies' Dispensary and Hospital of Cleveland.

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# GASTRON

## An Alcohol-free Extract of the Gastric Glands

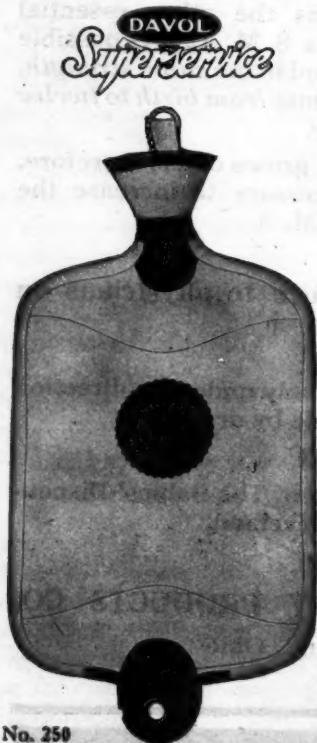
**GASTRON** is obtained by direct extraction from the entire mucosa, including the pyloric membrane, of the fresh stomach of the pig in an acid-aqueous-glycerin medium.

Gastron presents in a stable potent form a complete gastric gland extract containing the constituents of the entire gland tissue, as well as those of the peptic cells.

Gastron is designed as a clinical resource in disorders of gastric function.

In 6 oz. amber vial without lettering, in order that it may be prescribed in the original container.

**Fairchild Bros. & Foster**  
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Are made from the finest  
and purest selected rubber

Over capacity, unlosable stopper. Soft,  
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Hold the heat longer and will  
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